# Quality Measure Initiative Effectiveness

(FY2022 Appropriation Act - Public Act 87 of 2021)

## March 1, 2022

***Sec. 1646.*** *(1) From the funds appropriated in part 1 for long-term care services, the department shall continue to administer a nursing facility quality measure initiative program. The initiative shall be financed through the quality assurance assessment for nursing homes and hospital long-term care units, and the funds shall be distributed according to the following criteria:*

*(a) The department shall award more dollars to nursing facilities that have a higher CMS 5-star quality measure domain rating, then adjusted to account for both positive and negative aspects of a patient satisfaction survey.*

*(b) A nursing facility with a CMS 5-star quality measure domain star rating of 1 or 2 must file an action plan with the department describing how it intends to use funds appropriated under this section to increase quality outcomes before funding shall be released.*

*(c) The total incentive dollars must reflect the following Medicaid utilization scale:*

*(i) For nursing facilities with a Medicaid participation rate of above 63%, the facility shall receive 100% of the incentive payment.*

*(ii) For nursing facilities with a Medicaid participation rate between 50% and 63%, the facility shall receive 75% of the incentive payment.*

*(iii) For nursing facilities with a Medicaid participation rate of less than 50%, the facility shall receive a payment proportionate to their Medicaid participation rate.*

*(iv) For nursing facilities not enrolled in Medicaid, the facility shall not receive an incentive payment.*

*(d) Facilities designated as special focus facilities are not eligible for any payment under this section.*

*(e) Number of licensed beds.*

***(2) The department and nursing facility representatives shall evaluate the quality measure incentive program's effectiveness on quality, measured by the change in the CMS 5-star quality measure domain rating since the implementation of quality measure incentive program. By March 1 of the current fiscal year, the department shall report to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, and the senate and house policy offices on the findings of the evaluation.***

MDHHS

Michigan Department of Health & Human Services

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**Purpose**
The nursing facility Quality Measure Initiative (QMI) payments provide supplemental funds to invest in quality improvement efforts.

QMI payments to nursing facilities are based on their Quality of Resident Care Measure domain rating on the Nursing Home Compare (NHC) website, along with a resident satisfaction survey factor. Additional provider tax payments are used to generate approximately $73 million in funding annually.

The Centers for Medicare and Medicaid Services (CMS) publishes the 5-Star Ratings as a resource for families seeking information on nursing facility's performance. The measures are: Health Inspections, Staffing Levels, Quality of Resident Care Measures, and Overall Rating. Each measure is rated on a scale of 1-5 stars, with 5 stars being the best. The QMI payments are only based upon the Quality of Resident Care Measures, which are derived from the Minimum Data Set resident assessments, completed by nursing facility nurses. The measures include conditions such as the percent of residents who are physically restrained, have symptoms of depression, use of antipsychotic medications, have falls resulting in major injuries, have pressure ulcers, etc.

**Eligibility**
To be eligible to receive a QMI payment, a provider must meet the following conditions:

- The provider must be a Class I or Class III nursing facility. Most facilities are Class I nursing facilities which are proprietary or nonprofit nursing facilities that do not fall under any other Class definitions. Class III nursing facilities are proprietary nursing facilities, hospital long term care units, and nonprofit nursing facilities that are county-operated medical care facilities.
- The provider must have a 1, 2, 3, 4 or 5-Star Quality of Resident Care Measure on the NHC website.
- The provider must be a Medicaid-certified nursing facility.
- The provider must not be designated as a Special Focus Facility (SFF) by the CMS. SFFs receive more frequent surveys due to their record of high number of survey citations. Michigan is required to identify 2 SFFs each year.
- If the provider has an average Quality of Resident Care Measure below 2.5 stars, they must submit a Corrective Action Plan to the Long-Term Care Policy Section of MDHHS. The provider must deliver at least one day of Medicaid nursing facility services at the room and board level during the state fiscal year in which they receive QMI payments and in their immediate prior year-end cost reporting period.

**Distribution Method**
Payments to individual nursing facilities is determined by: (1) their Quality of Resident Care Measure; (2) Medicaid utilization rate; (3) number of licensed beds; and (4) use of a resident satisfaction survey.

1. Quality of Resident Care Measure

The individual nursing home's Quality of Resident Care Measure portion of their QMI payment is calculated for the first six months of the fiscal year. Fiscal Year (FY) 2022's payment tiers per star is listed below:

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Payment tier for the first six months of FY 2022:

| | |
|---|---|
| Five-Star Payment | $1,137.28 per licensed bed |
| Four-Star payment | $952.96 per licensed bed |
| Three-Star payment | $768.64 per licensed bed |
| Two-Star payment | $584.32per licensed bed |
| One-Star Payment | $400.00 per licensed bed |

2. Medicaid Utilization Rate and 3. Number of Licensed Beds

The adjusted QMI amount is multiplied by the number of licensed nursing facility beds licensed by the Department of Licensing and Regulatory Affairs to determine the QMI payment for the year.

Per-bed QMI payment amounts are multiplied by a Medicaid utilization scale. The Medicaid utilization scale is applied as follows:

- Nursing facilities with a Medicaid utilization rate of above 63%, the facility receives 100% of the QMI payment.
- Nursing facilities with a Medicaid utilization rate between 50% and 63%, the facility receives 75% of the QMI payment.
- Nursing facilities with a Medicaid utilization rate of less than 50%, the facility receives a payment proportionate to their Medicaid utilization rate.

4. Resident Satisfaction Survey Data

If a nursing facility submits its resident satisfaction survey data, it receives 100% of the QMI payment. If the nursing facility does not submit its resident satisfaction survey data, it receives 85% of the QMI payment.

**Corrective Action Plans**

Providers with a Quality of Resident Care Measure below 2.5 stars must file a QMI Corrective Action Plan with MDHHS to be eligible for QMI payments. The Corrective Action Plan must provide details on how the provider intends to use QMI funds to increase quality outcomes. If a nursing facility fails to provide a Corrective Action Plan, they are ineligible to receive a QMI payment for the State fiscal year.

Six months later the MDHHS requests an Action Plan Status Report. This follow-up to the Corrective Action Plan is voluntary for nursing facilities and does not impact their QMI payments.

**Data**

**Table 1: Quality Measure Totals**[1]

[1] Please note that the fiscal year corresponds with the quality data used for the QMI calculations for that year; FY22 Q4 is referencing 202106.

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| | |
|---|---|
| Increased Quality Measure Between Data Used for First Quarter and Fourth Quarter FY22 | 91 |
| Decreased Quality Measure Between Data Used for First Quarter and Fourth Quarter FY22 | 148 |
| No Change in Quality Measure Between Data Used for First Quarter and Fourth Quarter FY22 | 219 |
| Increased Quality Measure Average Between Data Used for FY21 and FY22 | 194 |
| Decreased Quality Measure Average Between Data Used for FY21 and FY22 | 149 |
| No Change in Quality Measure Average Between Data Used for FY21 and FY22 | 94 |

**Table 2: Average Quality Measure Rating Trend by Quarter**

| Quarter | Quarter by Date | Average Quality Rating |
|---|---|---|
| **201512** | December 2015 | 3.5 |
| **201603** | March 2016 | 3.5 |
| **201606** | June 2016 | 3.5 |
| **201609** | September 2016 | 3.5 |
| **201612** | December 2016 | 3.5 |
| **201703** | March 2017 | 3.7 |
| **201706** | June 2017 | 3.9 |
| **201709** | September 2017 | 4.0 |
| **201712** | December 2017 | 4.0 |
| **201803** | March 2018 | 4.2 |
| **201806** | June 2018 | 4.2 |
| **201809** | September 2018 | 4.1 |
| **201812** | December 2018 | 4.1 |
| **201903** | March 2019 | 4.2 |
| **201906** | June 2019 | 3.7 |
| **201909** | September 2019 | 3.8 |
| **201912** | December 2019 | 4.0 |
| **202003** | March 2020 | 3.9 |
| **202006** | June 2020 | 4.0 |
| **202009** | September 2020 | 4.1 |
| **202012** | December 2020 | 4.1 |
| **202103** | March 2021 | 4.0 |
| **202106** | June 2021 | 3.9 |

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**Table 3: Corrective Action Plans**

| | FY20 | FY21 | FY22 |
|---|---|---|---|
| Number of Facilities Required to Submit a CAP | 37 | 39 | 25 |
| Number of Facilities Who Submitted a CAP | 33 | 38 | |
| Number of Facilities Required to Submit a CAP Two Years in a Row | 15 | 14 | |

**Conclusion**

Nursing homes continued to be uniquely impacted by the COVID-19 pandemic. There was a continued emphasis on infection control issues and resident satisfaction has been impacted by procedures in place throughout the pandemic. As a result, it continues to be difficult to draw significant conclusions relative to the efficacy of the quality incentive payments themselves during this reporting period.